

**New Jersey Department of Health and Senior Services
Certificate of Need and Acute Care Licensing
PO Box 360
Trenton, NJ 08625-0360**

Reporting Year

ANNUAL REPORT OF MEGAVOLTAGE RADIATION UNIT

INSTRUCTIONS:

Please complete all questions and submit to above address by March 31.

FOR STATE USE ONLY

ID Number																													
I. IDENTIFICATION																													
Name of Facility Submitting Report										Location of Megavoltage Unit (if different from Submitting Facility Address)																			
Street Address																													
City					State					Zip Code					City					State					Zip Code				
II. TYPE OF MEGAVOLTAGE																													
Photon										Electron																			
_____										_____																			
_____										_____																			
_____										_____																			
_____										_____																			
III. PERSONNEL OPERATIONS DATA																													
Operator Occupation (Do NOT Provide Names)															Personnel FTE¹														
a. Radiation Oncologist ²																													
b. Radiological Physicist ²																													
c. Radiation Therapist ²																													
d. Registered Professional Nurse ²																													
e. Other (specify):																													
IV. UTILIZATION																													
Category										Linear #1					Linear #2					Linear #3									
1. Types of patients treated ²																													
a. New Patients ³																													
b. Retreated Patients																													
TOTAL PATIENTS																													
2. Number of patient visits ⁴																													
a. New Patients																													
b. Retreated Patients																													
TOTAL VISITS																													

**ANNUAL REPORT OF MEGAVOLTAGE RADIATION UNIT
(Continued)**

IV. UTILIZATION, Continued			
Category	Linear #1	Linear #2	Linear #3
3. Number of Treatments (ports) ⁵			
a. New Patient Treatments (ports)			
b. Retreated Patient Treatments (ports)			
TOTAL TREATMENTS			
4. Number of patients treated by electron beam			
a. New Patients ³			
b. Retreated Patients			
c. TOTAL			
5. Number of brachytherapy patients: _____			
V. TREATMENT PLANNING ²			
1. Does your facility have a simulator? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. If "No," what other means of treatment planning is used?			

3. Is your megavoltage unit used for simulation purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. If "Yes," how many hours was it used during the year? _____			
5. Number of patients simulated at your facility:			
a. Simulator: _____			
b. Other: _____			

Name	Title	
Department	Telephone Number	
Signature	Date	

Footnotes:

¹ One full-time equivalent (FTE) is to be considered equal to a 5-day, 40-hour week or 2080 hours per year. For fractional Equivalents, use 2080 as a base.

² Required by N.J.A.C. 8:43A-30 and N.J.A.C. 8:43G

³ A patient who has never before received radiation therapy or a returning patient with a second primary cancer (at a different site) which has not been previously treated.

⁴ Number of times a patient reports to the facility for treatment.

⁵ Application of radiation on one cancer site with one type of radiation modality.